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By

Gail R. Wilensky, Ph.D.

John M. Olin Senior Fellow, Project HOPE

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Mr. Chairman and members of the Budget Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I chair the Medicare Payment Advisory Commission. I am also a former Administrator of the Health Care Financing Administration. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences running HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or MedPAC.

My testimony today primarily discusses the Administration's programs for Medicare and prescription drug coverage, the need for reform and the extent to which the Administration addresses these needed reforms. My testimony also briefly discusses the Administration's proposals for Medicaid reform and the proposals for the uninsured.

The Administration's Medicare Proposals

The Administration has proposed a program to modernize and reform Medicare that spends $64.2 billion in fiscal years 2002 – 2006 and $153 billion in fiscal years 2002 – 2011. This is in addition to $2.5 billion set aside for FY 2001 that is not included in the five or ten year numbers.

The long-term reform plan has not yet been submitted, but the Administration's principles for reform include preserving Medicare's current guarantee of access, a choice of health plans that includes the option of purchasing prescription drug coverage, covering the expenses for low-income seniors, streamlining access to new medical technologies, establishing an accurate measure of Medicare solvency and not increasing payroll taxes.

The Administration is proposing an interim and temporary program that provides assistance to low-income seniors and seniors with catastrophic drug expenditures until Medicare reform is enacted and implemented. The program, Immediate Helping Hand, provides funds to the states that would cover the costs of prescription drug coverage for seniors below 135% of the poverty line with no premium and nominal co-payments. Seniors between 135% and 175% of the poverty line would receive partial coverage. Catastrophic coverage would be provided for seniors with out-of-pocket drug costs exceeding $6000 per year.

The Need to Reform Medicare

Although Medicare has resolved the primary problem it was created to address, ensuring that seniors had access to high quality, affordable medical care, there are a variety of problems with Medicare as it is currently constructed. The Administration has correctly assessed the most important of these flaws: inadequate benefits, financial solvency, excessive administrative complexity and an inflexible Medicare bureaucracy.

A part of the motivation for Medicare reform clearly has been financial, particularly concern about the solvency of the Part A Trust Fund. Part A funds the costs of inpatient hospital care, Medicare's coverage of skilled nursing homes and the first 100 days of home care. The Part A Trust Fund is primarily funded by payroll taxes. The changing demographics, associated with the retirement of 78 million baby-boomers between the years 2010 and 2030 and their increasing longevity, mean that just as the ranks of Medicare beneficiaries begins to grow, the ratio of workers to beneficiaries will begin to decline. Even with the strong economy of the last decade and the slow growth in Medicare payments since 1997, current projections show Part A Trust Funds payments exceeding Part A income by 2010 and its assets exhausted by 2025.

As important as issues of Part A solvency are, the primary focus on Part A as a reflection of Medicare's fiscal health has been unhelpful and misleading. As the Administration has made clear, Part B of Medicare, which is financed 75 percent by general revenue and 25 percent by premiums paid by seniors, is a large and growing part of Medicare. Part B currently represents about 40 percent of total Medicare expenditures and is growing substantially fast than Part A expenditures and about 5 percent faster than the economy as a whole. This means that the pressure on general revenue from Part B growth will continue in the future even though it will be less observable than Part A pressure. It also means that not controlling Part B expenditures will mean fewer dollars available to support other government programs.

However, as the Committee understands, the reasons to reform Medicare are more than financial. Traditional Medicare is modeled after the Blue Cross/Blue Shield plans of the 1960's. Since then, there have been major changes in the way health care is organized and financed, the benefits that are typically covered, the ways in which new technology coverage decisions are made and other changes that need to be incorporated into Medicare if Medicare is to continue providing health care comparable to the care received by the rest of the American public.

Much attention has been given to the fact that the benefit package is outdated. Unlike almost all other health care plans, Medicaid effectively provides no outpatient prescription drug coverage and no protection against very large medical bills. Because of the limited nature of the benefit package, most seniors have supplemented traditional Medicare although some have opted-out of traditional Medicare by choosing a Medicare risk or Medicare+Choice plan.

The use of Medicare combined with supplemental insurance has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with annual premiums varying between $1000 and $3000 or more. The supplemental plans have also meant additional costs for Medicare. By filling in the cost-sharing requirements of Medicare, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increased Medicare costs.

Medicare has also struggled with coverage decisions for new technology. The processes currently in place have been complicated and time-consuming and frequently have meant that seniors get coverage for new technologies years after the rest of the populations. This was true for heart and lung transplants a decade ago and was true for Positron Emission Topography (PET) until just recently.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health-status among seniors. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. These large variations in spending mean there are substantial cross-subsidies from people living in low medical cost states and states with conservative practice styles compared to people living in higher medical cost states and states with aggressive practice styles.

Assessing the Administration's Medicare Proposals

The Administration correctly understands Medicare needs reform in many dimensions. Medicare's benefits are clearly outmoded, but Medicare's problems extend beyond the absence of prescription drug and catastrophic coverage. Medicare needs to be modernized to accommodate the needs of the retiring baby-boomers and to be viable for the 21st Century.

During the campaign, the President's long-term modernization of the Medicare proposal was modeled after the Federal Employees Health Benefit Plan (FEHBP) and the work of the Bipartisan Commission for the Long Term Reform of Medicare. The principles provided for the President's plans to reform Medicare are consistent with these models of reform but the specifics of such a reform have not yet been proposed. Instead, only the first step included during the campaign, a temporary, short-term strategy to help low income seniors and seniors with catastrophic expenses, has been presented.

The budget as presented raises at least two questions. If there is a lack of agreement about other areas of reform, should a prescription drug benefit be added to traditional Medicare now, with reform to follow some time in the future? If not, is there any place for a temporary program of prescription drug coverage and how should that program be designed?

Although I believe a reformed Medicare package should include outpatient prescription drug coverage, I believe just adding this benefit is not the place to start the reform process. The most obvious reason is that there are a series of reforms needed to modernize Medicare. To introduce a benefit addition that would substantially increase the spending needs of a program that is already financially fragile without addressing these other issues of reform is a bad idea.

I personally support reform modeled after the FEHBP. I believe this type of structure would produce a more financially stable and viable program and would provide better

incentives for seniors to choose efficient health plans and/or providers and better incentives for health care providers to produce high quality, low-cost care. This type of program, particularly if provisions were made to protect the frailest and most vulnerable seniors, would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program for the plan that best suits their needs.

I am aware that the FEHBP model remains controversial with some in the Congress, but I think it's important that committee members understand that many of the most vexing problems of FEHBP are also present with the current combination of fee-for-service Medicare and Medicare+Choice plans, e.g. risk adjustment, providing user-friendly information, protecting vulnerable seniors, etc. But whatever the model of reform the Congress chooses to pass, the direction of the reform, a timetable for its implementation and important first steps should be determined before any major, new spending commitments are added to Medicare.

A second reason to proceed with some caution is the recognition of how difficult it is to correctly estimate the cost of a new additional benefit. Our past history is this area is not encouraging. The cost of the ESRD (end-stage renal disease) program introduced in 1972 was substantially under-estimated. The estimated cost of the prescription drug component of the catastrophic bill passed in 1988 and repealed in 1989 increased by a factor of two and one-half between the time it was initially proposed and the time it was repealed. The new estimate of prescription drug spending by the elderly recently released by the Congressional Budget Office forecasts drug spending will rise at an average of 12

to 13 percent per year for the next decade instead of the 11 percent per year projected last year. This means that the estimated cost of prescription drug bills already proposed, including the President's, is too low. The new cost estimate for H.R. 4680, passed last June is $213 billion over 10 years instead of the original estimate of $160 billion and the plan proposed by House Democrats would be $440 billion over 10 years rather than $330 billion.

In addition to cost and estimating concerns, important questions remain about how best to structure a pharmacy benefit. Most recent proposals have made use of pharmacy benefit managers or PBM's as a way to moderate spending without using explicit price controls. These strategies, when used by managed care, showed some promise for a few years ago although more recently they have seemed less effective. But most PBM's have relied heavily on discounted fees and formularies and only recently have begun using more innovative strategies to more effectively manage use and spending. If Medicare is to make use of PBM's, decisions will need to be made about whether and how much financial risk PBM's can take, the financial incentives they can use, how formularies will be defined and how best to structure competition among the PBM's.

All of these issues taken together suggest that legislating a stand-alone prescription drug benefit addition to traditional Medicare is not a good idea. Given our history, the cost is likely to be severely underestimated, the design issues are difficult, the structure and design of a reformed Medicare program are still subject to dispute and the program remains financially fragile.

The best strategy would be to agree on the design of a reformed Medicare program and begin to implement changes now. It is likely to take several years to build the infrastructure needed for a reformed Medicare program and to transition to a new program. Producing the regulations needed to implement the controversial legislation needed for a drug benefit will take at least two years. A reasonable interim step is to put in place a temporary program providing prescription drug coverage to help those most in need.

There are at least two ways a temporary program of prescription drug coverage might be designed. One way is along the lines of the Administration's proposal, i.e., a grant program to the states that allows state to extend existing pharmaceutical assistance programs, expand Medicaid coverage or introduce new programs, following in the model of the Children's Health Insurance Program (CHIP). The advantage of this strategy is that it builds on assistance programs already existing in 26 states and doesn't require new Federal regulations. However, there are a variety of disadvantages to this strategy as well, i.e., it requires new legislation in states that don't already have assistance programs, state pharmacy assistance programs may not be good designs for a regular Medicare benefit and may set a bad precedent, it may be difficult to convince states to pursue a temporary program and ending a block grant may be more difficult than starting one.

A second type of interim strategy would be to provide pharmaceutical coverage first to those populations who already get special treatment under Medicare, that is, the qualified

Medicare beneficiary (QMB's) and the specified low-income beneficiaries (SLMB's). This strategy addresses most of the disadvantages of the block grant program but it requires agreement on many of the design issues already noted and also requires the issuance of new regulations before it can be implemented. Both of these suggest benefits might not actually be provided in the near-term.

Whether or not the benefits of providing an interim program of outpatient prescription drug coverage for selected needy populations is worth the costs, is a decision the Congress will need to make. Congress might well decide it's not worth the political capital it would take and focus its efforts directly on broader Medicare reform, which will also include a prescription drug program.

If Congress does not enact Medicare reforms this year, it should be wary of using any spending that has been set aside for Medicare reform for the purpose of further increasing payments to providers. While some justification could be made for the Balanced Budget Refinement Act passed in 1999 and the Beneficiary Improvement and Protection Act passed in 2000, the improved financial status of many types of providers under Medicare and the higher projected spending rates for Medicare in the coming decade suggest Congress should act with great caution. MedPAC recently reported that total margins for hospitals in FY2000 appear to be greater than 5 percent, up from 2.8 percent in 1999. The financial status for other providers is less clear and while a variety of changes need to be made to the way they are reimbursed, whether or not payments need to be increased should be carefully assessed.

The Administration's Medicaid Proposals

The specific programmatic changes to Medicaid and the Children's Health Insurance Program (CHIP) that the Administration will be proposing are not yet available. The expectation is that the Administration will introduce changes that will increase state flexibility and encourage the use of private insurance and coordination with employer-sponsored insurance.

The Administration's budget does not reflect legislated spending increases in Medicaid. The budget does, however, include a savings estimate of $17.4 billion over 10 years. This reflects a proposal by the Administration to further restrict the effects of the "upper payment limit" loophole. The upper payment limit has involved the use of a higher payment for purposes of collecting the Federal share of Medicaid, with a forced rebate to the states, which has allowed states to effectively increase the Federal share in Medicaid spending. The final rule published by HCFA last year partially closed this loophole but still allowed some states to continue the practice for years and expanded the arrangement for non-State government-operated hospitals. The Administration proposes prohibiting any hospital plans approved after Dec. 31, 2000 from receiving the higher payment limit proposed in last year's final rule.

The concerns raised by the Upper Payment Limit practices raise a more general concern about Medicaid. The presumption underlying the current Medicaid program is that the state's share of the matching grant provides the basic incentive for states to moderate

spending under Medicaid. However, the states have shown themselves to be very creative in devising financing strategies which effectively increases the Federal share of the match beyond that which exists in law. Provider taxes and voluntary donations plagued the program during the 1990's; upper payment limits and inter-governmental transfers continue to plague the program. In this environment, the interest in increasing state flexibility increases concerns as to whether state actions will be budget-neutral or cost increasing to the Federal budget. With recent CBO projections of a 9 percent average annual growth rate in Medicaid for the next decade, any further attempts by states to increase their Federal matching share and thereby reducing incentives to be cost-conscious, are worrisome. It may be time once again to consider moving to a block grant program based on the number of individuals below certain income levels or a per capita block grant covering individuals within specified income levels. In return for this increased flexibility, states would need to provide information on the health status and use of services by people covered by the grants. This would be mean the Federal Government would have more information on the effects of its program than it has with the current Medicaid program.

The Administration's Proposals on the Uninsured

The Administration is proposing a multi-pronged strategy to provide support for the uninsured, including refundable tax-credits, investments in community health centers, a reform of the National Health Service Corps and an investment in a health communities innovation fund. This strategy recognizes that as important as it is to provide increased

insurance coverage to the uninsured, there will be a continuing need to fund the so-called health safety net. This is both because there are likely to be substantial numbers of uninsured individuals irrespective of the precise program that is adopted and because even for some individuals with insurance coverage, there may not be adequate health resources to provide the care that is needed.

The tax credits are part of the Treasury Department's budget. The budget sets aside $26.4 billion over ten years, some of which is for individuals who don't have access to employer-sponsored health insurance. The precise amount has not yet been released. The HHS budget includes $124 million for FY 2002 as part of a multi-year commitment to increase the number of community health centers by 1200 and double the number of people served. $400 million for FY2002 is budgeted to provide funding for innovative local organizations addressing various local health care needs. The National Health Service Corp reform primarily reflects a management effort that will improve the targeting of the neediest communities.

The question of whether the proposed refundable tax credit is likely to induce the purchase of private insurance is an area in which there is considerable debate. The decision to increase insurance coverage by providing financial assistance to individuals to purchase insurance as opposed to increasing eligibility for public programs is a first order decision that the Congress must make. The remaining budgeted items represent substantial efforts to improve the health care infrastructure.

Let me summarize my points as follows:

The Administration proposes to spend $153 bil. in FY 2002-2011 to modernize and reform Medicare

- -- Specific provisions of long-term reform not yet submitted
- -- Funding includes support for temporary program providing assistance to low income seniors and seniors with catastrophic drug expenses

Medicare needs to be reformed

- -- Current Medicare program has inadequate benefits, questionable financial solvency, excessive administrative complexity and excessive bureaucracy

Adding a stand-alone drug benefit without further reform is very risky

- -- Imprudent to substantially increase the spending needs of a financially fragile program
- -- Actual costs of a new benefit will be underestimated if history is any guide
- -- Design issues of a drug benefit are difficult and have yet to be determined

Starting now to implement a reformed program is a good idea

- -- Building the infrastructure will take time
- -- Future seniors need to know the design of the future Medicare program
- -- Future seniors will be different from today's seniors in terms of work experiences, health plan experiences, income and education

Temporary program for those most in need is a reasonable interim step

- -- Possible designs include a block grant to states or coverage limited to populations currently getting special treatment, e.g. QMB and SLMB populations
- -- Temporary program may not be worth the political capital it would require

Congress should be wary of spending Medicare reform funds to further increase provider payments

- -- Financial status of some types of Medicare providers has improved substantially

Administration proposes a $17.4 bil legislated savings from Medicaid

- -- Proposal involves tightening the upper payment limit provisions
- -- "Creative financing' by states combined with interests in increased flexibility may necessitate different structure for Medicaid than current matching grant program

Administration has multi-pronged strategy for the uninsured

- -- Refundable tax credits to encourage the purchase of private insurance
- -- $124 mil. in FY 2002 to increase the number of community health centers
- -- $400 mil. in FY 2002 to fund innovative local organizations